COMMUNITY HEALTH WORKER : CRITIQUE OF AN EXPERIENCE

VANAJA RAMPRASAD

REPORT OF THE STUDY ON THE COMMUNITY HEALTH PROGRAMMES FUNDED BY

OXFAM (INDIA) TRUST, BANGALORE.

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ACKNOWLEDGEMENT

It has been a learning experience to visit remote parts of the country to observe the dynamics of social change and understand the positive and negative aspects of health development.

I wish to thank Mr.Jeff Alderson, Field Director, Oxfam (India) Trust, Bangalore for giving me this opportunity.

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Many thanks to the different project coordinators who willingly provided hospitality and shared all the information. Some of the project visits being very pleasant memories.

Most of all I wish to express my heartfelt thanks to the hundreds of CHWs who enthusiastically communicated their knowledge and skill.

Lastly, I thank the staff of Oxfam (India) Trust, Bangalore, Stanely, Sandra, Barbara, Janet and Teddy who gave me a lot of encouragement and support that I needed before each field trip.

VANAJA RAMPRASAD

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SUMMARY OF MAIN FINDINGS

Ten community health projects funded by OXFAM in which Community Health Workers - locally selected and trained were an important component, were evaluated to identify positive and negative factors that enhance or obstruct respectively the evolving role/potential of the CHWs.

POSITIVE :

The projects that show some indication of developing the potential of community health, through CHWs have had the advantage of a well-planned and organised work through a committed leadership.

Training inputs in few of the projects have been effective.

There is a great potential in the illiterate women, who have been trained and there is scope for upgrading their skills as seen in some of the projects.

Some of the projects have gone beyond traditional medical services to raising awareness and organising people around their problems.

Sustained effort over a long period is required to see the impact of health development, which was seen in a few projects.

NEGATIVE :

The Community Health Worker programme has been used most often as a focal point for funding.

Most projects had a limited understanding of the concept of VHW.

Some projects give little or no support to the CHW by way of supervision/ upgrading of skills.

Turnover of staff has been a very great limitation in many of the projects, affecting continuity of care, planning and supervision.

The projects lack skill in evaluating their own work through minimal record keeping, and a regular inbuilt critical analysis.

1.1 INTRODUCTION :

It is a well-known fact that about 70 to 80% of India's people do not have access to even the most elementary public health services. It is also known from the past experiences that 70 to 80% of the illness seen in these populations do not need doctor's services. The realisation of the above two facts lead to the re thinking on health policy in the country. While attention was focussed on reaching the services to the interior areas, the creation of a cadre of local village based health workers became a primary aim. The model was evolved in a modest scale by several voluntary organisations with the backing of many funding agencies and then adopted in a big way by the Government.

In the mid-seventies, Oxfam gave a tremendous support to the training of the village health workers. In the early eighties Oxfam reviewed the outcome of these health programmes it had supported and as a result decided to study training of the community health workers (CHWs) and the impact of their work. The projects chosen by Oxfam were either those that received funding from Oxfam or training input alone or both. At the time of evaluation only two out of the nine projects were continuing to receive financial support. The projects are located in and around the three southern states - Tamil Nadu, Andhra Pradesh and Karnataka (see Appendix for case studies).

1.2 TERMS OF REFERENCE :

The initial terms of reference of the evaluation as set out by Oxfam were very broad and included the following :

1. An assessment of the overall health problems in the project areas pin-pointing the underlying causes;

2. Services offered by the institution and the village health workers including objectives and actual arrangement of work;

3. Assessment of the community health programmes including the involvement of the institution (e.g.,) the hospital and the communities planning and providing these services;

4. Profile of the village health workers including age/sex, status, relationship to the communities;

5. The training of the VHWs including initial training and follow-up;

6. Supervision of the VHWs including their remuneration ;

7. Attitudes of - (a) institution and the communities to the VHWs and (b) CHWs to the institution and the communities and to their work including turnover;

8. Utilisation of services provided:

   - What percentage of population was covered;
   - What socio-economic caste group benefit?

9. Changes following the setting up of the programme in :

   - incidence of disease
   - rate of input and maternal mortality
   - nutritional status

- anemia rate
- usage of water and sanitary facilities
- nutrition
- family planning and child spacing

10. Effects of other socio economic programmes on community;

11. Cost of the programmes to the institutions and the communities and the funding of these, as well as opportunity cost for the user of these services; and

12. Relationship between the Community Health Programme and the Government health services.

As a prelude to the suggested study, initial discussions with the concerned training staff (of Oxfam) and the study of the files of the different projects were undertaken. Based on this, the objectives of the study were reformulated and some broad areas of the study were indicated. However, we still had great reservations on the availability of information from the projects.

Should Record Keeping be over-emphasized? Yes, because -
Proper and only essential records kept periodically help in evaluating the objectives of the programmes.
Participation of the staff in understanding the record-keeping gives a feedback of the programme to the staff themselves.
Better understanding of the programme by the staff encourages involvement of the staff in the programme.
Makes possible internal evaluation of the programme.
Makes possible feedback of the results to the target population.
But, if projects find it impractical it is because,
The expertise to plan and implement and information system is not available within the group.
Trained people are not immediately available to implement the system.
It is time-consuming and expensive.

While undertaking a post-hoc evaluation such as this, it must be emphasised that :

1. All these projects were service projects and not health research projects, except MGS-G, which was an action research in community health.

2. Data maintained and information processed by them were very minimal to the extent of documenting quantitatively their various service components in an annual report.

3. Starting a project is never so neat as seen on paper and the methodology evolves gradually. Hence a predetermined evaluation procedure cannot be imposted. Under these circumstances it was decided that the original terms of references were too ambitious. Therefore they were reformulated as follows :

   1. Assess the training efforts and the supervision structure of the village health worker programme;

   2. Assess the community participation and understanding of the VHW programme;

   3. Provide profiles of the CHW (age, caste, class, marital status, understanding of her role, attitude to community, sense of self-worth, whether the job has provided opportunity for self-actualisation, whether role has improved self-image, improved ability to relate to others, etc);

   4. Assess the socio-economic and political status of the client group;

   5. Assess the changes in the infrastructure of the institution in keeping with the Community Health Objectives.

   6. Assess the impact of the ancillary programme (i.e.,) feeding, Balwadi, etc., on the village health worker programme.

As for the assessment of the technical performance of the village health worker, it was felt that -

1. It would not be possible to work out a criteria to measure this since little or no data is likely to exist at the project level which could be used;

2. Other factors besides the VHW could have led to the improvement of the health status of the community; and

3. There was no commonality in the programme to define common criteria for measurement.

It is realised more and more that a single cook book approach as remedy for the health problems cannot be applied in all settings, considering the variety of cultures and wide range of differences in the environmental settings and different values, interests and expectations of people and the project organisers.

Hence this whole exercise of evaluation was approached with the understanding that every new action, every proposal is bound to contain seeds of conflict and many a times voluntary groups find their way into the community by trial and error. Therefore, it was thought worthwhile to understand this process by which groups have evolved their work or abandoned their work. Throughout the period of study and while interacting with groups, an attempt was made to combine the available quantitative data with qualitative observations in order not to be carried away by what numbers can project. The emphasis on interpreting the work of each group was on the development of process rather than on the progress or performance.

1.3 METHODOLOGY :

"Evaluation is complex process involving both subjective and objective measurements. There is no one unique way of performing an evaluation since evaluation becomes judgement ultimately. However, as long as it is understood that the main purpose of evaluation is decision making and not condemnation or approbation, unavoidable subjectivity is no impediment". (ICMR, 1980).*

With this underlying concept of evaluation, the projects were contacted and the purpose of the study was explained. One of the apprehensions on which the study was formulated were, that there was little or no clarity about the exact role and function of the CHW by both Oxfam and the projects. It was assumed that her usefulness lay in the fact that she was from the village and thus able to understand the mores and values dictating the behaviour of the client group. Therefore, she would be a good via media for health education and a medium through whom the project staff would find it easier to relate to their clientele.

It was not clear at that stage why the projects or existing institutions accepted the whole community health package sponsored by Oxfam which would have implied changing their institutional set-up to gear up for this change. Or were CHWs being accommodated as an additional programme without any commitment to structural change? It was also not clear whether the CHW was seen as an important link in the health delivery chain to whom more and more skills needed to be transferred in response to the needs expressed by the community or if she was merely a front line 'lackey' of the hospital/health centre system? In other words the question was - Did the role of the health worker expand and evolve with the growing experiences of the project and did this contribute to an understanding within the institution ?

In order to fulfil the objective of the study and answer many of the questions,field visits to these projects were undertaken. In the absence

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*quoted in Ashish Bose, P.B.Desai 1983 "studies in social dynamics of Primary health care" Hindustan Publishing Corporation (India).

of a data base at the field level as well, we had to resort to the limited information available. Other sources of information were -

- observations in the field;
- discussions with the management;
- interview with the field staff;
- interview with the VHWs;
- interview with the beneficiaries including the health committees; and
- study of the project reports, annual reports and other interim evaluatory reports.

2.0 PROFILE OF PROJECTS :

The projects selected for the study were located in the States of Tamilnadu, Karnataka and Andhra Pradesh. Each project was different from the other with regard to the model, mainthrust of the programme population covered, the number of CHWs trained and other supportive programmes (Table 1). Therefore the projects offer a variety. The size of the projects differed in that, they ranged from covering just 5 to 110 villages. The content of each of the projects built around the health services also varied. Within this given limitation, an attempt is made to understand and evaluate the various components of the CHW programme.

Table II describes the participatory components of the CHW programme. It is observed that though some of the projects score well on certain components, there are some points on which they score very low. For eg., all the projects lack a system of evaluation and monitoring of progress and feed back to the community.

3.0 OVERVIEW OF THE ISSUES RELATED TO COMMUNITY HEALTH WORKERS :

A. ROLE OF THE CHW :

Primary health care which has been the concern of government, voluntary groups and international agencies is still evolving as a concept. The varied experiences in the field, offer a wide variety of approaches. In examining the percepts and practices of such experiences, there emerges a dichotomy between reality and the concept. For example, in concept PHC is community oriented but invariably it turns out to be project oriented. In concept it is an outcome of the felt needs of the people but in reality felt-needs are far from what PHC planners would wish them to be. Again, in concept PHC should grow within the support of health care infrastructure but in reality it grows in a vacuum. Very often PHC is expected to be self-sufficient and community supportive. But in reality self-sufficiency is a runaway optimism. Lastly, PHC in concept, should encompass a multisectoral approach, which in reality is seldom realized.

The role of a community health worker in a primary health care programme, is easy to define if the first two concepts of primary health care are real. That is, if the PHC is community oriented and is an outcome of the felt needs of the people, then the role of the community health worker fits into the expectation of the people. On the other hand, when PHC is project oriented, the community health worker is merely grafted on to a situation where role expectations and performances do not match.

In principle, PHC implies reduction of the widening gaps between those who have access and those who do not have access to resources, such as income, food, employment, education, etc. It postulates a re-distribution of resources and a strong sense of self-reliance of people. But seldom has this been understood by implements of health programmes. Therefore, the role of the community health worker invariably in all the projects was reduced to two main functions.

One was to act as a link between the main programme and the people, to refer or motivate the people who need medical care to avail the services and to give health education to these people on a routine basis. The latter was more informative rather than enabling.

In an attempt to render health education and building awareness, the health worker merely repeated the same message through available flash cards. Thus, the health education was in no way geared to the needs of the specific situation or problem. If, on the other hand, the health workers were taught to spread the message of the importance of under-five care and if this had been followed up by her conducting regular under-five clinics, the message through "praxis" would have been clear both to the worker and the women in the community. Thus, a transference of health knowledge and skills would have occured from the professionals to the lay man which focus the basis of a community health programme and which also entails the acceptance and practice of rational health behaviour by the common man.

The approach of the health workers was found to be mainly at an individualistic and family-oriented level. The impact had not been felt at the community level. Therefore, since job descriptions were not defined, the training most often was also not designed to produce a cadre of health workers who could rise to the occasion to meet new challenges. Collating from the experience of all the projects the following composite role of a CHW emerges - the minimum expected of the CHW was to function as a 'lackey' during the mobile clinics, and render health education during home visits. Some projects went a little further to involve them in record keeping like plotting of weights of children. Only two of the projects (HKS-T and MGS-G) saw the potential in them to be responsible for minimal curative services. In some of the projects the CHWs were active in organising people around their problems. Only one project (MSG-G) had developed the skills of the CHWs to carry out laboratory tests during the clinics. In reality however, with the exception of two projects none of the others were able to generate this total potential in their programmes.

B. SELECTION OF COMMUNITY HEALTH WORKERS :

The selection of the community health worker is a complex issue involving the community, local leaders, trainers and the project holders. There is general understanding that the CHWs need to be broadly representative of their clientele as well as acceptable to all significant sub groups. The profile of selection of Community Health Workers was - The CHW should be a local worker, middle-aged, without encumberance, illiterate, with enough time to spare for health work and be willing to render service regardless of caste bias.

Community participation - Does it mean better acceptance of programme inputs?
YES,
Because people have participated in planning the programme and hence it would reflect the felt needs of the people.
Because people have had a role in identifying the CHW and hence better rapport between them.
The CHWs are better respected and this respect can be gradually used to introduce preventive orientation at a community level.
The CHW can work at the community level and not stop at individual family level.
NOT ALWAYS,
Because community participation is misinterpreted as - convincing the community to participate in supporting the CHW financially. Beyond contributing a small sum, people do not understand the implication of people's representative of health needs and her role.
Because, people's expectations differ very much when they pay.
Because, people lose interest very soon, since they have not understood the philosophy.

In most of the projects the health committee of the people chose the CHW according to a few criteria like a middle aged woman, illiterate and who has the time to spare, for community work. The woman preferably should be acceptable by all groups/castes of the community. There was no clear reasoning why it should be women. Project MGS-G had demonstrated training men as CHW and then were able to provide the necessary services in the maternal child health programmes.

The selection criteria was adhered to, in all the projects, but it was in the process of selection that they differed very much. It was always not possible for the community to select the CHW. Implicit in the concept of community participation is the idea that it is a democratic way of selecting the CHW and invariably the leaders will select those workers who are best suited for the community. But in the Indian situation, the village usually is a collection of socially stratified smaller communities with vested interests. Very often there is the danger of the health committee itself being constituted by a few dominant caste members. If that is the case, the selection of the CHW through them would only serve vested interests of the community. "Community participation" is one of the terms most often distorted and misinterpreted to mean - a handful of formal/non - formal leaders taking a leading role in making decisions. Under such circumstances, one can be sure of non-participation by the minority groups who are the oppressed groups. When such situations prevail, the project team is faced with the dilemma of having to step in with ideas to neutralise this bias. Hence in some projects, names were proposed by the committee but the final selection was through a formal interview.

C. TRAINING OF THE COMMUNITY HEALTH WORKERS :

a) Content :

The effectiveness of training depends greatly on, who does the teaching and what training methods are used. What CHWs should be taught depends a great deal on what they will do and the knowledge, attitudes and skills they must possess. What they will do moreover should be in keeping with their potential capabilities and in line with local health priorities.

In the typical CHW training sessions undertaken at the projects, there is an attempt at imparting knowledge on disease causes, preventive action, remedial steps and simple disgnostic methods. Though the curricula centered around the themes mentioned above, the education media was, the set of flas cards available from CMC-Vellore. Only HKS-T and MGS-G had programme of lesson plans upgraded periodically. In some of the projects, the chapters from the book, "Where There is no Doctor" were used as lessons during the teaching sessions. The teaching was very prosaic, in the form of lectures and tended to be didactic. Very rarely were the CHWs involved in a dialogue.

Skills form the heart of 'practical' sections of training. Again skill development depends on what the programme envisages from the CHWs. Some of the projects demonstrated that it is possible to prepare the illiterate CHW for skills such as giving injections, taking weights, monitoring the growth of the child through the growth chart, preparation of oral rehydration fluids, dressing of wounds and dispensing simple medicines. These were demonstrated by projects like - MGS-G, HKS-T, DNS-A, and THS-T. This apart, CHWs were helped to develop the skill to solve problems and make decisions, especially those related to disgnosis, referral and treatment.

It is observed from the experience of all the projects that there are somewhat contradictory approaches - namely acceptance of community's needs for curative care and the planner's cost effective interventions like preventive actions.

As for the different projects of interest to Oxfam, in at least 5 of the projects the training of the community healthk worker was initiated by Oxfam. Invariably the projects saw the training of health worker as one way of ensuring funding from Oxfam and not as a need based programme. In some of the programmes, whatever might have been the initial training, it was found that subsequent training, in-service training, etc., were very poor.

The only form of knowledge transference that occured between the trainer and the health worker was at the monthly meeting. Also in many of the programmes, the health worker's field training which should have been upgraded by the supervisory team was lacking. At the same time, there were some projects, where the awareness of the CHWs to the socio-political background to health problems was found to be high. This was directly related to the training skills received by the CHWs from the project team members. Many of the projects also did not have the necessary training personnel (within the project) or an ongoing in-service training.

Health priorities for Action and Training: Should community or planner reference predominate ?

COMMUNITY PREFERENCE -

Community participation for various activities like construction or cleaning may be forthcoming if health priorities respond to feltneeds.

Health workers are more respected if they respond to felt-needs.

PLANNER PREFERENCES -

As certaining community preference is time consuming and must be done before training starts.

Communities are aware of the diseases but not the causes.

It is always not true that the people know what they need.

TRAINING MATERIALS AND METHODS :

b) Manuals and teaching materials were scarce in many programmes and those used were sometimes considered inappropriate. Many projects based their teaching on the set of flash cards produced by the Christian Medical College, Vellore. It was not clear whether projects found practical difficulties in locating the appropriate health education material suitable to the local situations, or whether they merely accepted the use of these cards. There are arguments in favour and against producing materials locally. If they are produced locally, the materials are better understood because they reflect the local health problems and their causes, the cultural factors reflecting the health behaviour including health related vocabulary. At the same time it is true that producing materials locally needs investment of professional time a good understanding of communicating health messages, which was lacking by and large. As mentioned already the methods used were very prosaic. Innovative methods like Role play, skits, songs and education through examples in the environment were used very rarely in some projects.

EVALUATION AND FOLLOW-UP OF THE CHWs

c) Some of the qualities seen in the community health workers were their willingness to offer assistance with a sense of responsibility to the patients, and fellow workers. They had a good grasp of the theory and technical details taught to them. Their ability to carry through a given task was found good. But none of the projects except MGS-G and HKS-T had a system by which the CHW could be evaluated from time to time. This offered very little scope for upgrading their skills. Some of the projects provided a support system to monitor the work of the CHW, while a few totally lacked even the support system. The support system was through mobile clinics when the CHWs referred the cases that needed more attention and coordinated programmes like immunization or eye camps or school health check-ups.

Community health workers being a new phonomenon in most countries, there is much controversy over professional standards for them. There is little doubt over the need for desirability of assessing CHW knowledge and skills before, during and after training to stimulate learning and inform trainees about their own progress. Many programmes elsewhere have tested community health workers as a certifying process and other times simply to help trainees identify weak areas.

HKS-T recruited young girls with high school level literacy. Their training model included evaluation through written exams and practicals. Besides this project, the others, where illiterate women were trained there were no systems of evaluating the women. MGS-G involved the CHW continuously in a variety of skills that helped in upgrading their status within the project. Their monthly meetings helped in assessing their grasp of the problems.

EVALUATION OF TRAINING AND HEALTH IMPACT :

The following are considered as essential for good training.

1. Use of participatory learning techniques.
2. Emphasis on practical skills rather than on abstact knowledge.
3. Use of appropriate technology.

These aspects were rarely observed in the training methodology adopted.

CHW performance may be the best available proxy measure of health impact, but standardized methods of assessing it are not readily available. One of the potentially useful means of assessing CHW performance is to measure its effect on the community's health, knowledge and practices especially in areas relating to prevention and early treatment of diseases. On the other hand, direct measurement of changes in health status can be costly and time-consuming and it is usually difficult to know whether a particular programme is responsible for any changes detected. To measure drop in IMR, or other such sensitive indicators, a rigorous information system is necessary which is seldom found in projects.

CONCLUSION :

The varied approaches and understanding of health and development only show that community health is still evolving as a concept. The overall analysis shows that the community health workers were not integrated into the programme after a process of internal evaluation. Very rarely the project settings internalised the CHW concept as increasing people's autonomy over health care through their own representative. The role of the CHW was limited to a large extent because of the professional bias, fear of giving room to 'quacks' and generally hesitation to take risks. The experience of many of the projects (except a few) in evolving a training methodology has been rather a maiden attempt and a very amateur approach. There was the assumption that the training of CHW and the health education was an end in itself.

In general, many of the questions concerning the CHW are not answered. They are :- What is the role of the CHW? Who are they accountable to? How does one keep the balance between technical training and adequacy of social and development aspects? Who are they supervised by? Are the CHWs accepted by the community? What priority do health projects have in local development ?

One of the chief issues that emanate from the findings of this study is the role of the funding agency. The idea of the CHW has been introduced to the projects by Oxfam followed by the training of health workers and funding of the programmes. In introducing the concept of the health worker the initial training responsibility was undertaken by Oxfam persons. Subsequently, follow-up of the training and development of the role of the health workers was neglected.

Furthermore, when grafting the concept of health worker to the particular institutional set-up, little or no effort was mode by the agency to create the framework within it, for adequate supervision, training and record keeping. Many of the projects did not possess the skill and, as a result, there remains a vaccum in this sphere. To maintain, therefore, that the programmes have become self-sufficient after brief period of Oxfam's help would be erroneous. In many cases, the programmes have come to a standstill after the withdrawal of active support (both training and financial) by Oxfam.

Funding, to many of the programmes has not led to change of perspective, though it has resulted in change of programmes. The experiences from the different projects is a mixture of some positive and negative aspects.

RECOMMENDATIONS :

As an output of this evaluation, some recommendations are made to Oxfam on policy for funding of health programmes.

- Oxfam as a funding agency has to be selective in funding need-based primary health care programmes.

- Should support community health programmes which are a part of the total development of the people.

- The kind of training that requires remote control should not be undertaken.

- Needs of the programmes should be identified before the expertise from Oxfam can be offered.

- There is room for help from Oxfam to help projects with career plans for their health workers to improve and learn new skills.

- Oxfam should help projects reflect on their output and evaluate their work objectively. The framework for adequate supervision, training in record keeping is lacking and this vaccum should be filled by the expertise Oxfam can offer.

- Self - sufficiency in health care is a myth expecially if the focus is on disadvantaged and exploited sections. Funding should be ensured for a long enough period until it can be subsidized by local resources of the project.

In selecting a proposal for funding, the following guidelines are suggested:

- Is the programme need-based ?
- Does it include both curative and preventive services ?
- Is it part of an overall development plan ?
- Are the health services integrated with the overall development input ?

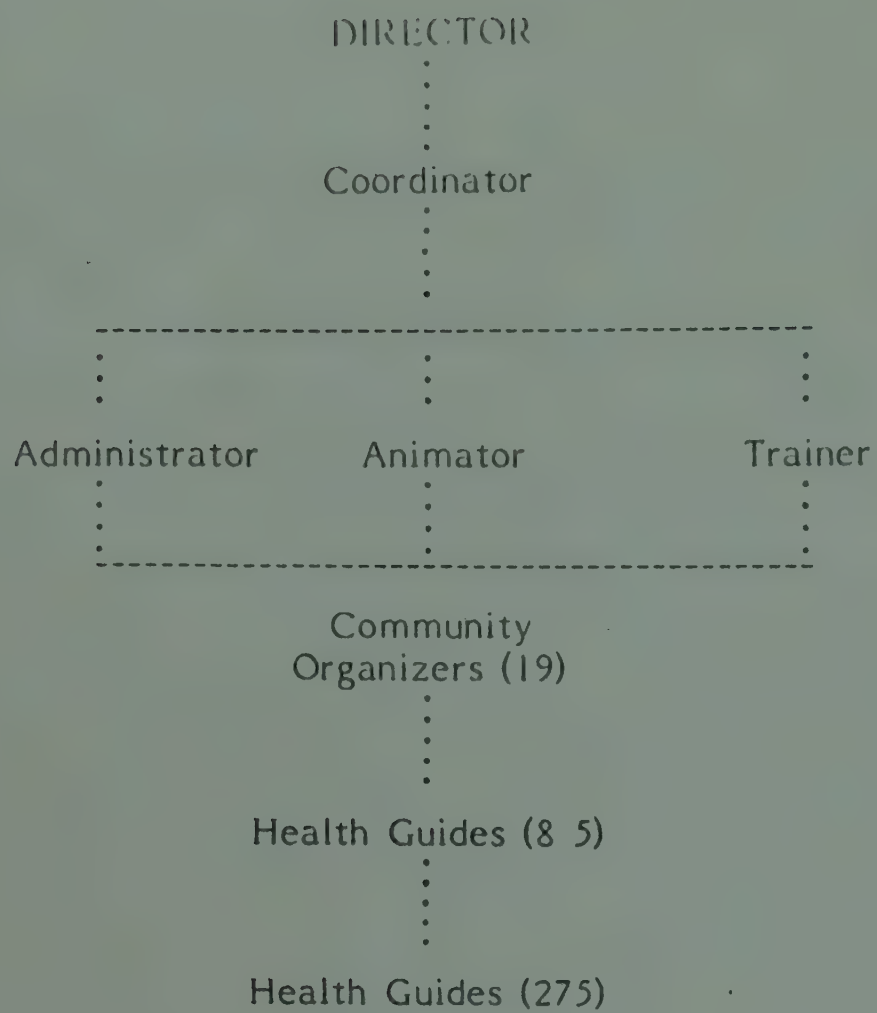
- Does the programme coordinate with the existing health facilities such as government, private practitioners, indigenous healers?

- Is there a referral system envisaged ?
- What are the training facilities ?
- Is there a sound base-line data available ?
- Who are the beneficiaries? Does the programme identify them ?
- Is there a system for keeping records and reporting ?

If at least 7 out of the 10 points are positive, then the proposal could be considered for funding. Besides Oxfam could also play a role in promoting these ideas amongst the projects already funded or those being considered for funding.

CASE STUDIES

HKS-T :



The Community Health Centres of the programme spread over a hundred villages sprang from a feeding programme under international aid. The package of services created consisted of take-home supplementary feeding, health and nutrition education and rudimentary forms of health care. The programme penetrated into one hundred and twenty four villages covering 38,000 families. This represented 75% of the eligible low income rural families with children under five in the district. Each child is weighed routinely once a month, with his weight recorded on a growth chart. Mothers receive their lessons in health and nutrition along with the supplementary food. The unique feature of this programme is the impressive out reach creating a high degree of interaction between the delivery system and its beneficiaries.

The highlight of this community health out-reach is the successful recruitment and training of the village girls to implement the programme on a day-to-day basis.

The centres were launched after many meetings between the organising group and the people. Although centres did not emanate spontaneously, in course of time, there was a rush of enthusiasm. Girls were recruited and given short orientation courses. When it was realized that hard work and slow progress was what was being offered, there was a waning interest. In due course people realised the potential for the girls in the form of education and employment. Over the years the training programme itself has undergone changes, to suit the needs of the community.

Training of the volunteers at different levels became a highly specialized function of the programme. The training programme of the health workers includes subjects like community development, leadership training, public health and hygiene, nutrition and family welfare. With increasing responsibility, the inputs increased. The training was done by a team of experts who are drawn from other sources as well.

A major factor contributing to the popularity of the programme was the back-up and infrastructure of the church. The district also provided a relatively easy and frequent communication facility. This together with the high literacy level of women have favoured the programme. For the same reason, the minimum literacy level of the health workers is no less than a school graduate and amongst the community organisers, it was not unknown to find firls who were post-graduates. the import-ance of supervision and back-up service has been emphasized in the programme. The system has iniated an endogenous process of creative and reflective action.

The impressive outreach has been evaluated from time to time. One of the studies (Osgood and Miller)* concludes that an extra-ordinary variation in the incidence and severity of malnutrition was seen in the villages that look much the same. They also report that objective social and economic conditions account for very little of this variation, because

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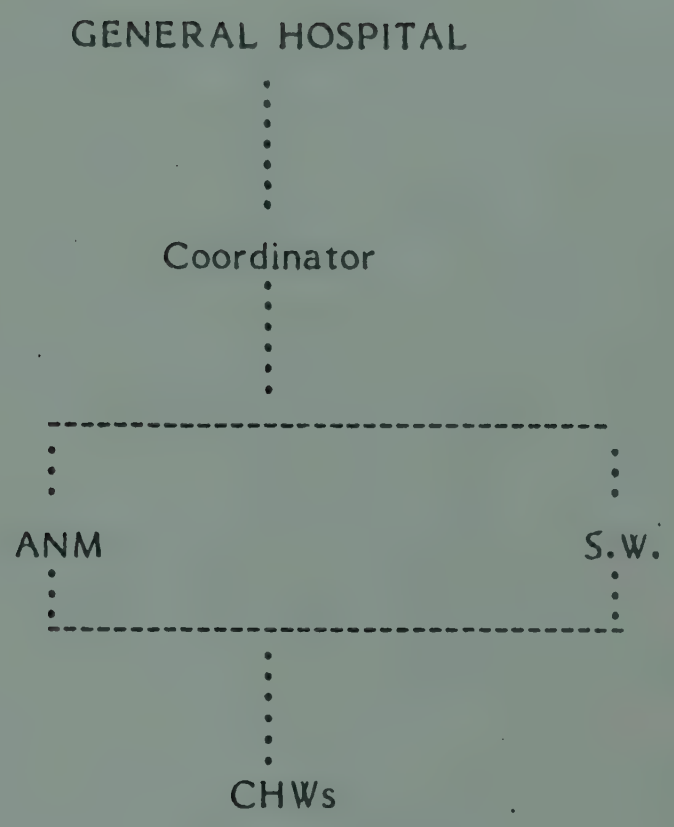
* John Osgood and Ray I Miller 1978, Development at the gross roots The organizational imperative.

of the power of exogenous influence such as the price of rice that overwhelms the usual distinction among people, which is a thin line. Much of the objective improvement fails to get at the underlying health dynamics of infection and disease which influence health and nutritional status. Conclusively this question is posed - Are the children served by the programme better off or was it just wishful thinking to expect nutrition intervention based on the delivery of services, no matter how well implemented, to improve the nutritional status of poor families when the broader context in which the interventions were introduced was so unfavourable to their well being.

The density of population in the district is highest for all India. The programme has done little towards encouraging small family norms. The programme lacks an inbuilt system of feedback. The impact is difficult to measure with a constantly changing target group.

HNS-K



It was a hospital based programme. The programme at present being run by the institution, is a package of services including - Mahila Mandals, Balwadi Centers, supplementary feeding programmes, maternity centers and the village health worker scheme.

The Mahila Mandals form the basis of services according to the organisers. There are 24 Mahila Mandals and nineteen Balwadies run by them.

Five of the Mahila Mandals have organized the services of the 'dai' Four of these centers have bed facilities and run maternity homes. In ten of the villages covered by the institution, there were sixteen health workers.

Mobile health unit, visiting the villages to support the health workers was not functioning at the time of the visit. The village health worker programme has not developed and has remained at a minimal level, due to lack of investment of professional time. The institution has a highly centralized decision making structure.

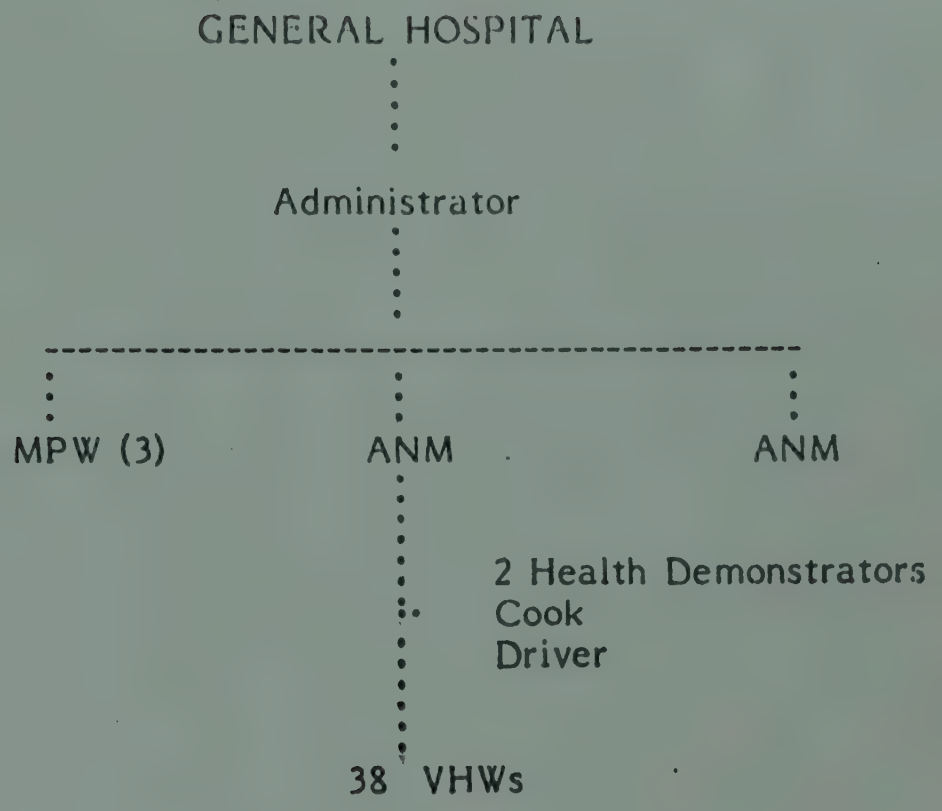
The role of the health workers as perceived by the institution was to be an educational and awareness building one. The health teaching was not geared to the needs of the specific situation or problem. It was inferred from the knowledge base of the health workers that their level of knowledge was poor. There were differences between health workers of different villages. The difference was due to the opportunity provided to one set of the CHWs to do curative work and hence they were in touch with specific problems of health care and its management.

There were no specific criteria by which the Health workers were selected. Some of the health workers interviewed were from the more dominant castes in the area.

The in-service training was observed to be very poor. No systematic training methodology in terms of curriculum or methods existed. The field training which should have been upgraded and continued was also lacking. The supervisory team consisting of a community worker and ANM were themselves not trained.

Nothing much can be said about the impact of services since no data-base exists, and no specific programme except the home visits by the health worker and immunization of children exists. Changes in health status cannot be commented upon since no base-line data or periodic recording existed for built-in evaluation. The role perceived by the CHW was one of disseminating health message. The CHWs saw the immunization of children as their main achievement, though no proper records were maintained. During the occasional immunization camps the CHWs merely motivated mothers through local announcement to get their children immunized. It was obvious that the CHWs did not see themselves as a link in the chain or as change agents. The mode of health education was very prosaic, unimaginative and routine.

HNM-A



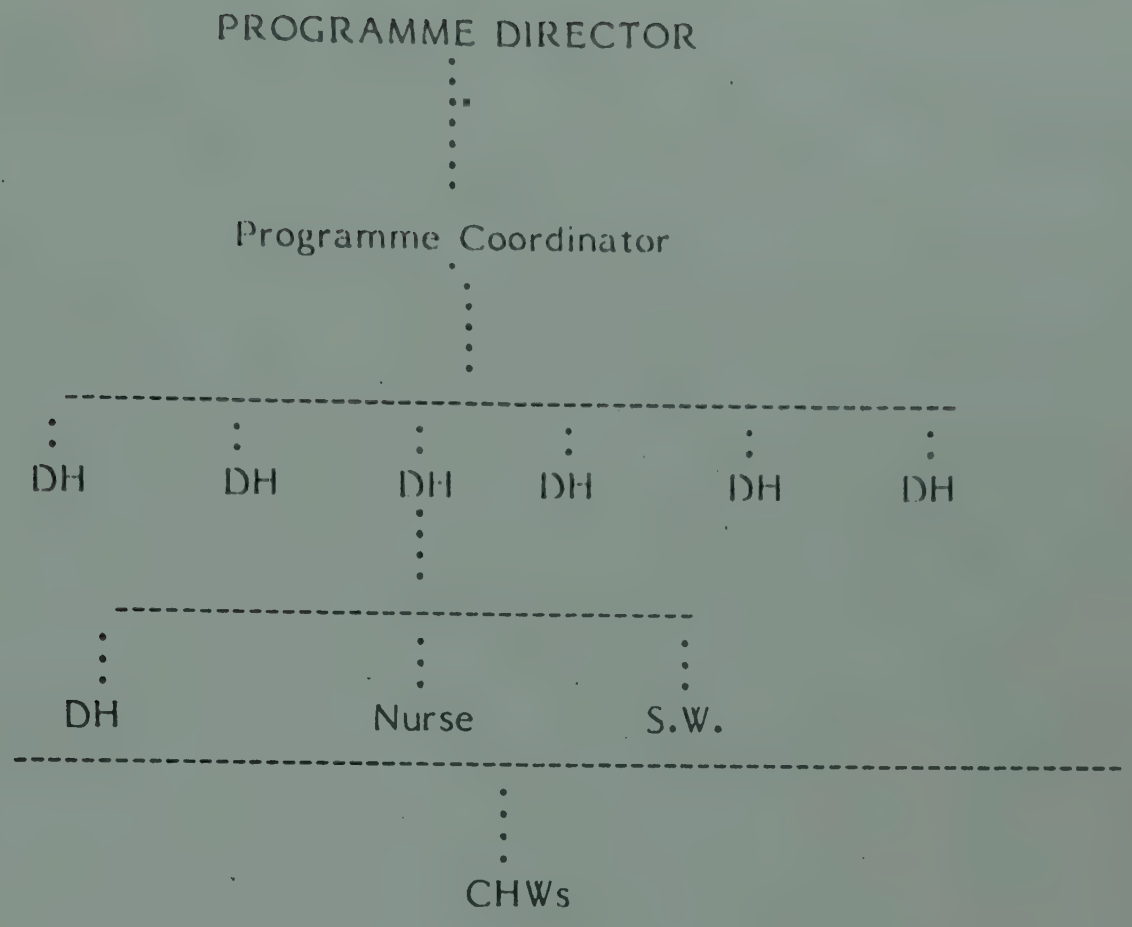
The hospital was situated in a drought-prone area of Andhra Pradesh and had within its fold the nutrition rehabilitation unit. As an outreach programme the hospital had a community health worker programme to cover a population of 40,000 in 34 villages with 38 community health workers.

The community health team was headed by the coordinator under whom work three multipurpose workers and two Auxiliary Nurse Midwives The multi-purpose workers were responsible for organising the health committees in the different villages, while the ANM's were in-charge of the curative services rendered in the villages.

The village health workers were all women in the age group 32-60 years. Fifty percent of the VHWs were widows, 65% of them having no education and the rest of them with very minimal education. Nearly 75% of them were traditional dais. The women, by and large, belong to poor socio-economic conditions. They were landless labourers who depended on their daily wages for their living, other than the income from the remuneration received as health workers. The CHWs have been selected by the mutual consent of the team and the village leaders. The criteria set down for selection were - the women should be middle aged and be willing to work as village health workers.

The training of the CHWs was done on a weekly basis in different batches. The classes were conducted centrally in the hospital premises. The syllabus followed was from the book "where there is no doctor".[3] Teaching aids consisted of flash cards, and occasionally slides.

Apart from health education, no other services were rendered by the CHWs. The data - base being highly erratic and disorganized, the impact could not be assessed as against the objectives. The immunizations coverage of a random sample of six villages show that the coverage for all doses is poor which negates the effect of the first dose. There is evidence to show that, under five-care and the impact of nutrition education has not been to the expectation since children have been admitted in the peadeatric ward with kwashiorkor and marasmus from the villages where the VHWs were working.



The main thrust of the hospital was leprosy control. In due course, the objective of the project was to control leprosy and tuberculosis with an aim of integrating it into general medical services and community health.

The community health programme covered seven neighbouring villages. Community health workers were trained as a part of the community health programme. The training included use of audio-visual aids, and the resources of a hospital to scientifically explain the germ theory and the need for asceptic conditions. The topics covered a wide variety of subjects like, diarrhea, nutrition, growth charts,leprosy, data collection and use of information.

The role perceived of the CHWs was to bridge the gap between the team and the people, help at the clinics, follow-up of the defaulters in long-term treatment in their homes. They were also expected to do simple dressings of wounds, treat scabies and to give health education.

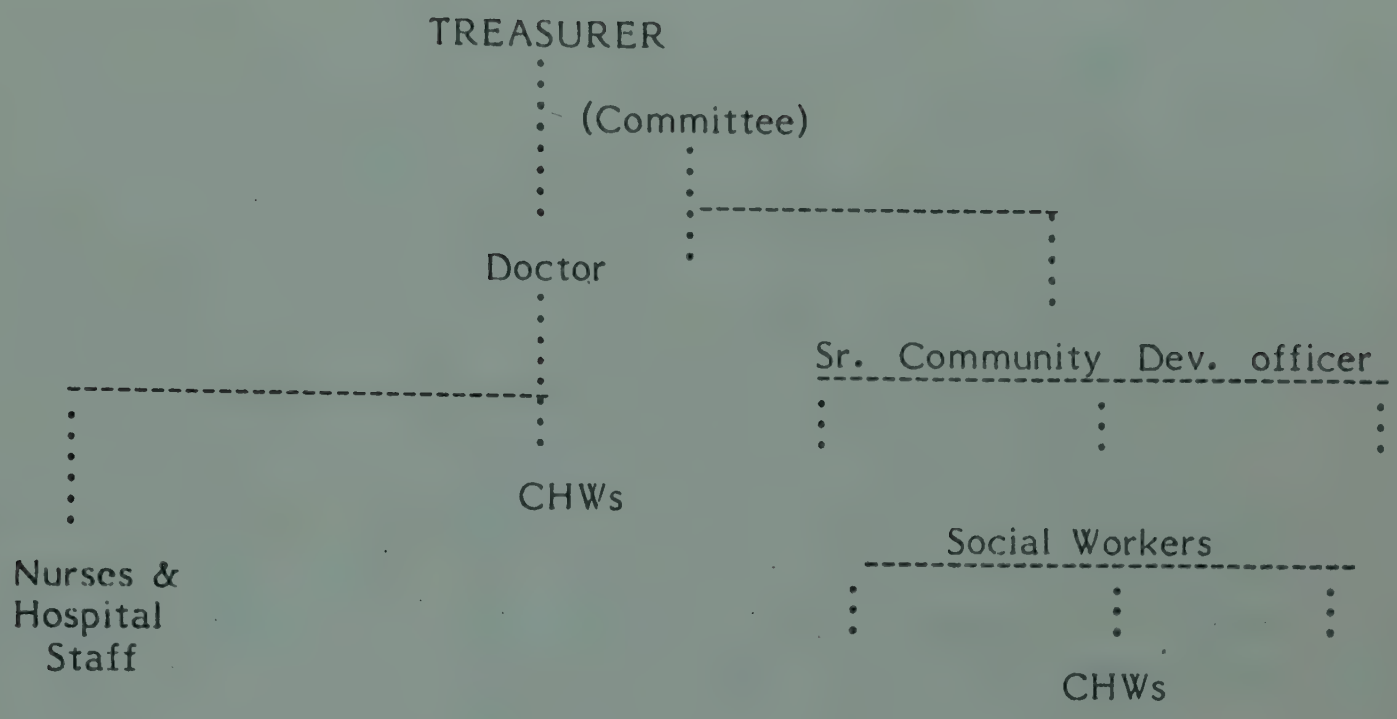
Adequate supervisory structure was incorporated. The CHWs were a mixed group of young and middle aged women of whom some were married and others single. The selection of the CHW was formal, through an interview of the candidates suggested by the leaders in the village. Willingness to work with the lower caste groups and aptitude

for the field work were spelt out as chief criterion. They received a remuneration of Rs.50, from the programme coordinators and it was hoped that the people would come forward to pay for their services.

Some of them who were able to read and write were encouraged to keep their records and diaries. They were not entrusted with medicines for curative purposes. They were proficient enough to identify various patches and referred these cases to the hospital. Their awareness of the general problems of poverty, oppression and exploitation could be rated as high. There were instances when women were organized to press for provision of clean water for drinking from the Block Development Officer. Willingness to continue work was expressed even if the stipend were to be withdrawn. The topics covered during the training were in keeping with the link between health and development. Apart from the topics on health and hygiene, mid-wifery, first-aid and wounds and their management, topics like leadership and group dynamics, women and development and nationalised banks, have been dealt with. Various media have been used in communicating the message. In service training is done once a week by the trained nurse-cum-social worker and the consulting medical doctor. Supervision and back-up service by the team was found to be good.

The response of the people to the services of the VHW was found to be apathetic and unconcerned. It was observed that the people's involvement in the services delivered to them was practically absent. The curative services were welcomed by the people.

TWS-T



The beneficiaries of this programme were members of the tribes inhabiting the formerly malarial jungle belt of the Nilgiri Hills. Formerly, they were semi-nomadic jungle tribes engaged in food gathering and hunting in their jungle environment. With the virtual elimination of Malaria their natural habitat was encroached upon for the development of coffee, rubber and tea plantations. More recently some of the land has been given to them and some are small cultivators eking a living from their land in not a very efficient way and often exploited by unscrupulous outsiders who offer too little. Traditional houses are built of mud and wood from the forests. The Kurumba tribe tend to live in small scattered settlements in rocky elephant infested areas and some of them still live under rocks and caves. The main illness treated at this programme was severe cases of anemia and malnutrition. Poverty and inadequate access to food have been at the root of their problems.

While Anemia and TB are rife, the tribes were also afflicted by a genetically transmitted sickle cell anemia which leads to early death, particularly among children and women. It is estimated that roughly 28% of the community is attacked by sickle cell anemia. Worm infestations of all kind aggravate the problem.

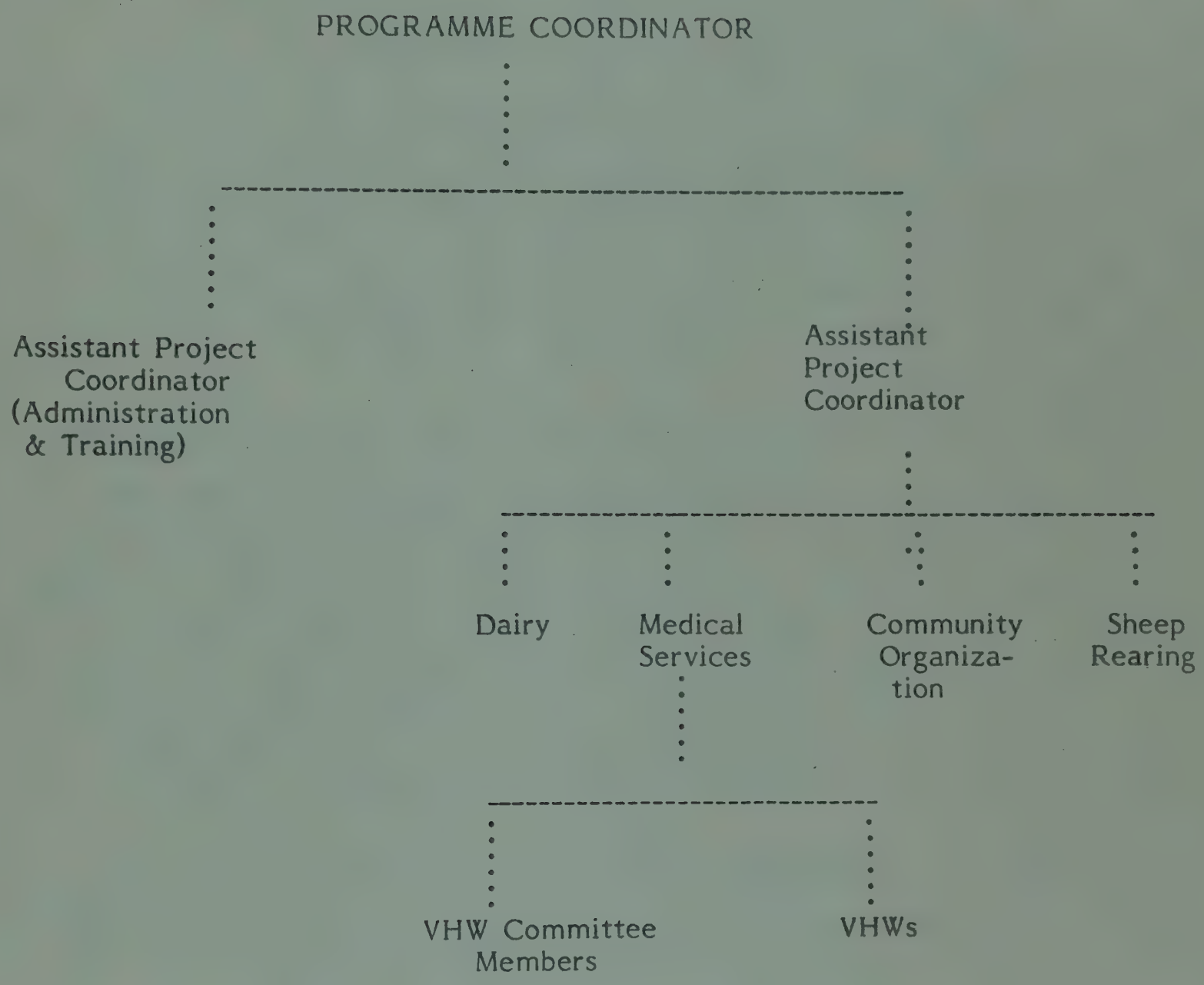
In the population studied there is a high rate of carriers of the sickle cell anemia :

Irulas	28%
Soligers	30%
Paniyas	36%
Kurumbas	35%
Mulukurumbas	36%

The years of service, has given the tribals confidence to come forward for medical aid at the hospitals and dispensaries. To extend the contact with the mothers at the MCH clinics, the concept of the CHWs took root. The training sessions were planned at the level of awareness of the tribal women. No formal syllabi was followed.

The teaching media was predominantly the set of flash cards. As a result, the topics covered were confined to flash cards that were available. The objective of the training was to visit the individual homes for health talk and refer the sick to the visiting centre. There were no records maintained by the CHW and no curative care was entrusted with them, nor were ante-natal and post-natal cases. The VHWs came together for a weekly sharing session, with the team headed by the doctor. From the impressions one has of tribals, as shy, retreating, unaware of the civilisation, it was impressive to observe them as articulate, willing to express their learning capacity and socialise with the rest of the world.

INS-K



INS-K

The health care component was one of the different approaches to reach the people by this programme. The primary objective of the health service was curative health, with the emphasis gradually turning on to preventive health. The procedure followed to select the CHWs was as follows - A public meeting with the people, the health committee consisting of village leaders and the programme staff is held. The health committee is assigned the responsibility of selecting three possible candidates. The criteria for selection of these women were laid down as follows - the women must be middle aged, acceptable to the community, not quarrel-some, without family responsibilities and willing to visit all the houses.

The CHWs were given 10 days of training. The training was based on the topics on nutrition, pre-natal care, tuberculosis, scabies, lice, sanitation and sore eyes. The work of the CHW was supervised by the health committee. The programme has worked out a sliding scale of remuneration from the organizers with a matching contribution from the people, over the years. The duties of the CHW include house visits, contacting all pregnants and lactating mothers, help in the immunization camps, conduct health education to impress on the preventive aspects of health.

The initial training of the CHW was done by Oxfam and subsequently followed up by the doctor. the training limited itself to topics available through the flash cards.

The members of the health committee lacked a clear understanding of the role of the CHW. The committees played a supervisory role rather than a supportive role. The committee did not represent the poorer economic strata of the community.

In the absence of a curative services by the CHW and a hierarchy of referral system, people's acceptance of the CHW was poor.

DGS-T

MEDICAL OFFICER (3)

Block Extension
Educator

Health Inspector - Basic Health (9)

Health Visitors F. M

Health Worker F. M

Total = 28.

Experimental programme on Nutrition

Community Nutrition Instructress

C.N.Supervisor	2	3	3	4

45
Community Nutrition Workers

DGS-T

The project was an outcome of a collaborative effort of the governments, to improve the quality of health care. Before the scheme was launched the project undertook experimental training programmes in different blocks by various institutions. One of the institutions invited was Oxfam (India) Bangalore. The training objectives were to develop primary health care delivery skills and management skills for the delivery of services. The training had to be conducted to various levels starting with Medical Officers, Block Extention Educators, Block Health Officers, Multipurpose Workers, male and female and ANMs.

Since the objective of the programme was to strengthen the existing schemes with a few additional inputs, it parallely experimented with a community nutrition programme. The population covered by this scheme in Kolathur block was 61,610. This block has been identified by the government of Tamil Nadu as a needy area in a backward district. The literacy level was as low as 23.2% and has a high infant mortality rate. The MPWs were expected to perform certain specific jobs as for example, the female MPWs take care of the registration of the ANC and PNC cases, ensure immunisation coverage, render health education and a whole range of primary health care services. The male MPW was in-charge of chlorination of wells, identification orf malarial cases, follow-up of treatment, treatment of minor ailments and referrals to the primary health centre. These MPWs were brought under one sub centre supervised by a health supervisor, each multi purpose worker being in-charge of 1000 population.

While the medical aspect of the programme was covered by the primary health care infrastructure the community nutrition work came under the nutrition centres and the production centres. There are four production centres where the women from the villages were involved in the cleaning and production of the mix. The feeding programme covered children below two years and six months, who needed supplementary

feeding. The children were phased out from the programme as they reach two years or in between if they have gained weight by more than a kilogram. Weight cards were maintained and the mothers made aware of the gain or loss in weight. This feeding programme was meant to fill the gap in covering children for feeding under the Balwadi scheme and the Chief Minister's mid-day meal which covers the age groups 3-5 years and above 5 years respectively. The programme also covered pregnant and lactating mothers. It was observed that the beneficiaries come to the centre at a time suited to them and there was no fixed time for feeding. Secondly, the mix was reconstituted into a ready to eat food by a very simple process of mixing the powder with hot water and reconstituting it as laddoos. The powder has been tested for its nutritive value and it was reported by the programme personnel that it has been simplified to just ragi, groundnuts and jaggery.

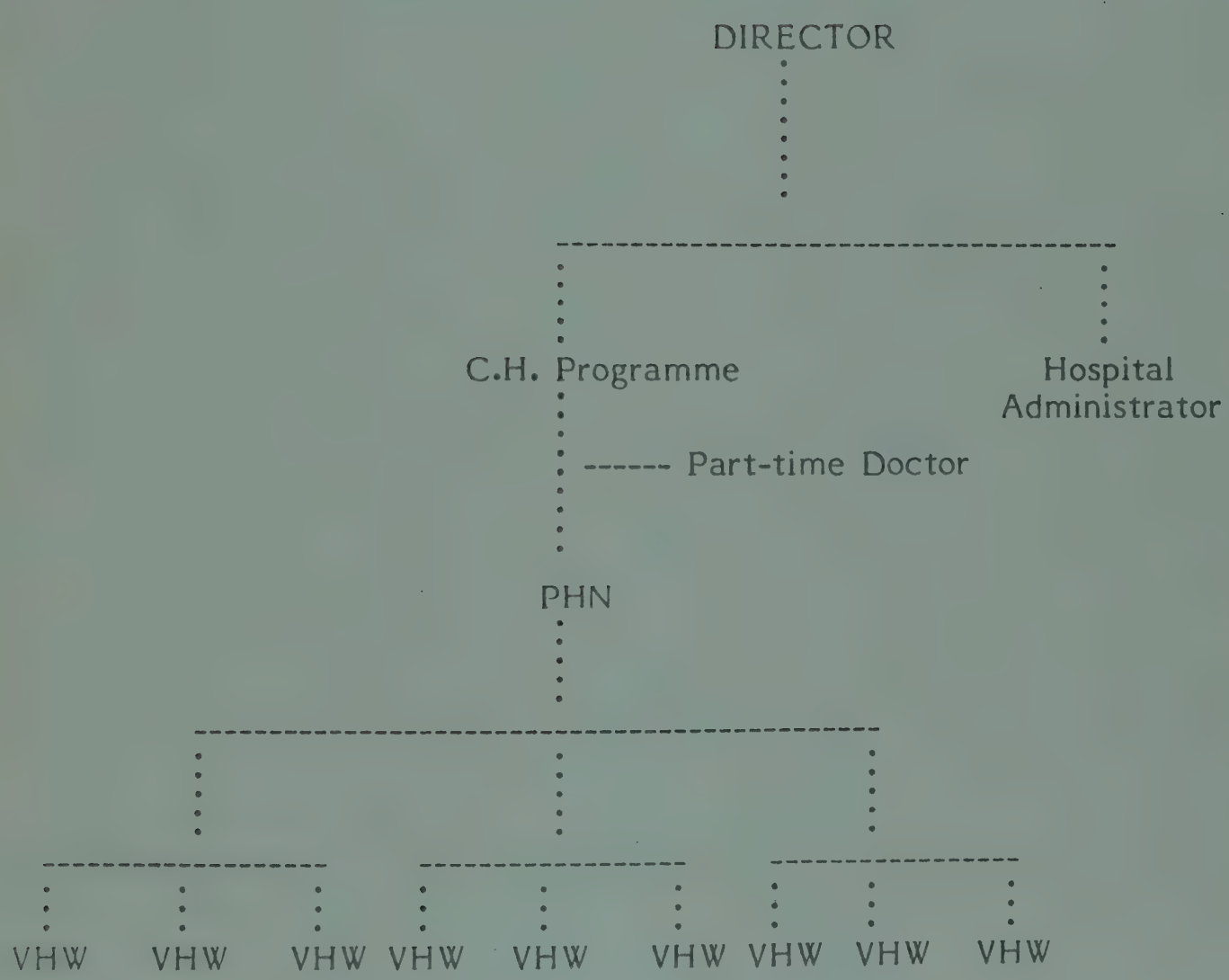
The community nutrition workers were similar to the VHWs in the voluntary organizations. They are lay people from the community. The criteria for selection was that they should be middle-aged, married/ widowed/deserted and from lower socio-economic strata and educated upto eigth standard. They received a small honararium of Rs.100/=. They were supervised by the Community Nutrition Supervisors who report to the Instructress.

It was difficult to assess the impact of services since the time span was too short. However, since the recording system was good, it was possible to observe the figures every month for a period of twelve months. It was interesting to observe that about 3.5% of the children who were enrolled for the feeding programme were removed due to increase in weight. There was no discernible difference between the two halves of the project in the percentages of children in the various grades of malnutrition. The IMR reported for the period seems to be very high with regard to figures for all India. The reason for this as explained by them was the prevelence of female infanticide.

The different institutions were given the freedom to design the training. The approach adopted was based on problem posing and solving and planning the sessions with the trainees. The topics for training could be grouped under attitudes, skills and knowledge. Out of the 30 topics, all thirty were held in the class-room and sixteen topics were also held in the field. The methods used were mainly, discussions of the topics.

As for the follow-up on the field, it was reported that it was done through incidental teaching on the spot. The final model, has been evolved out of the experiences of all the institutions that were invited for training. The in-service training to be imparted to the staff was based on this model and perhaps at a later stage, an evaluation done on the impact of the final model of training, may be worth considering.

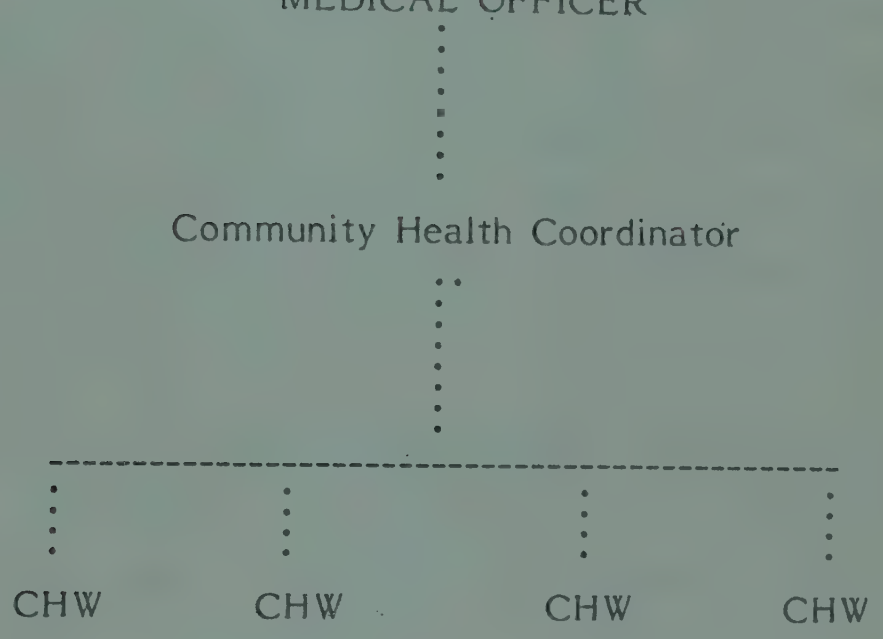
DNS-A



The community health project serves a population of 38,000 living in 22 villages within a radius of 7.5 kms around the hospital. The focus of the programme was centred around delivering comprehensive health care, with the backing of socio-economic programmes and training the personnel of the health team.

The CHWs who form the core of the programme consist of a composition of all castes and socio-economic strata. The CHW was trained to identify new patients and refer them to the hospital. The training also includes follow up of patients with chronic illness like leprosy, tuberculosis, diabetes, epilepsy and hypertension. The CHWs distributed high protein mix to the under-nourished identified by them. After a couple of years of exposure, have also been allowed to handle curative medicines. The team of nurses supervise the CHWs in the field. The weekly inservice training of the CHWs brought together a lively meeting of the CHWs and the team. Health education was rendered in the form of folk songs. The CHWs grasp of theory and technical knowledge was good and the ability and willingness to put knowledge to good use was rated as high.

RJS-A



Oxfam's financial support to this programme was obtained to extend the curative services into community perventive health in the year 1974. The programme commenced in 1975 and included the different components of community health such as ante-natal post-natal underfive care, immunization, treatment of T.B., scabies, malnutrition and the like. Community health programme envisaged was very similar to the conventional programmes of the social and preventive medicine department of a medical college. The programmes planned were highly compartmentalized and the unifying links to aim at a better quality of life were missing.

In due course, the leadership of Miss. M. was sought to organize the community health programme. Miss.M. brought with her the vast field experience, and the programme organization commenced with comprehensive base-line survey of the taluk, drawn to a large part, from secondary source.

With funding from Oxfam, also came the idea of training health workers as part of the programme input. The work commenced with a total population of 4080 spread into 15 villages (small hamlets). The choice of the CHW was by the programme organizers in consultation with the leaders of the village. The deep set caste barriers in the community, offered little choice for selection. Frequent in-service training programmes were conducted during which time more CHWs were recruited. Though the initial training was given by Oxfam, subsequent training programmes were organized by Miss.M. who was in-charge of the programme.

The periodical reports submitted by Miss.M. reflect the efforts to cover the different areas of the programme very systematically. The CHWs were included in the different activities like a simple survey, treatment of minor ailments and the under five followup. The involvement of the people in the porgramme confined itself to opinion seeking and consensus on programme introduction. Beyond this the involvement of the people had not taken shape.

The training was very similar to the style adopted by Oxfam in the other programmes. The important difference was-the subequent training sessions were followed up by a person within the programme. The scope of the training limited itself to the subjects in the falsh cards. Since the evaluation was done at a period when the CHWs were no longer active, the impact of training could not be assessed. Also the entire set of CHWs were not available for interview. But from the reports it is inferred that the CHWs had an opportunity to give a feedback on what they had learnt and gaps in their knowledge were handled during the training.

Between the years 1976-1978 the programme took time to find its feet. New staff were added. In the meanwhile, many small socio-economic programmes like the mat weaving, tailoring, dairy schemes for women had taken shape. By 1979 fifteen CHWs were trained but during the course of the two years, six villages were dropped from the programme, since coordinating the work became very difficult. From the curative and preventive services the programme also moved on to initiating non-formal education with vocational training for the youth, in carpentary, agriculture and sewing. During the first year, the focus was on the young boys and later it shifted to the older group. In the subsequent months, the programme continued to function with new staff who were trained in community health from Gandhigram. Very soon the programme was left without any staff to carry on the community health work. As a result, the programme was given a different twist to start the Balwadies in each of the villages and the CHWs were absorbed into the Balwadi feeding programme. The supply of milk powder came from Emmaus, Switzerland.

At the time of the evaluator's visit the community health programme was revived with the introduction of a young doctor into the programme. This young doctor considered this opening as a spring board for a better career and further studies in public health. The programme continued to function minus the CHWs. There were plans to add two new villages to the programme. It was understood that the doctor expected to leave the minute better opportunities lured him.

Some of the achievements the project claimed were-cent per cent sterlization in some of the villages and near cent per cent immunization for the children. The programme had a good rapport with the government health services. Some of the staff like the community animators were also the community health workers trained by the government under the Rajnarayan scheme of training community health workers.

The evaluator met the group of CHWs who were now serving as Balwadi Care-takers. The CHWs had no opportunity to practice their skills as health care workers in the present situation. They preferred to work as CHWs since they were only part-time workers and that permitted time for their own work. On the other hand, they had to forego their daily wages to work in the Balwadi and the feeling that they were underpaid prevailed. The project was in no position to allot more funds for their salaries. There was no certainty that the people would be willing to maintain the village health worker though there were indications that they did appreciate the Balwadi Services.

MGS-G

Located in the drought-prone backward area of Gujarat is an experiment in the approach to community health. The group consisting of three doctors and five social scientists have come together in this venture.

It included within its scope of activities two broad areas viz., Community Health and Education. Community health included curative services, health education, under five clinic, ante-natal clinic and the training of CHWs. The education services were extended to the tribal children from the neighbouring villages. The educational approach included vocational training in carpentry and tailoring among oher things like screen printing.

The community health activity was sharply focused on maternal and child health. While wondering what was new about MCH services by a team of doctors and social scientists for a small population, it was worth pausing to understand the rationale behind their work. Three points that emerged as striking features were - the project was not high powered and top heavy; no hierarchical levels existed in the organization; thirdly, the programme has not turned out to be a matter of routine activity. Their efforts to gear towards better maternal and child health arises from their analytical approach to understand the intricacies in the social forces that conjecture against the woman and the child.

Social transformation being a distant goal, every small venture attempts to find reasonable solution to the problems that surface. But if maternal and child health were to be conceived of as indicators of the community's well - being, the bolts and nuts of this indicator have to be well understood and aligned. MGS-G stands out in its efforts to get to the roots of the maternal and child health, to study its epidemiology and question every step in organising the services.

'Apparently', MGS-G appears to be no different from any other group delivering MCH services or organising health education. But the difference comes out sharply to a keen observer who is searching for answers to the trap many projects fall into. The unique feature was the questioning attitude of the group of intellectuals who have abandoned the 'profitable private practice' or adding to the 'brain drain' that beckoned them. This questioning attitude is backed by the 'action research' the group has sought to pursue. Research in a vacuum is of no benefit to the society and action-based on borrowed understanding of reality becomes routine activity. On the other hand, it has grafted research and action to contribute to the evolving science of community health.

MGS-G has taken the concepts of PHC into consideration before planning the services in a big way. Therefore, every input was questioned, tested and implemented. Located on the banks of river Narmada, the villages were typical of any other part of the country except that, three out of the 5 villages serviced, are tribal villages. The project covers a population of 5000 with 6 VHWs apart from the project staff. According to MGS-G there is a genuine effort to understand the felt-needs of the people though it was realized not always do people feel the need for what was ultimately good for them. Therefore, the empahsis was in creating health consciousness to the extent of making available services such as the under-five clinics, ante-natal clinics and follow-up of T.B. and leprosy patients. These clinics are conducted with the active involvement of the VHWs who have been given a proper grounding in understanding the epidemiology of under-nutrition and communicable diseases.

The morbidity load in the community has been observed through a longitudinal survey done by the VHWs. Through the survey the VHWs also understood the extent of communicable diseases in the community as 70% of the total morbidity reported, and 30% of infections were accounted for by the under-fives. Also 50% of illness reported were through diarrhea, respiratory infections and skin infections.

The CHWs have a clear concept of the growth chart through praxis. A rigorous follow-up of children show that 70% of the child population are below the lower line of the road to health which is mean - 2 standard deviation. As a further step in exposing the CHWs to the PEM nexus, they were involved in an intensive epidemological clinical investigation of cases of serious PEM. Through this, the VHWs were taken through the maze of causal forces of PEM. This exercise provided the CHWs with the skills to deal with the problem with confidence. Practical observations of weight loss in children during an epidemic of measles also provided an opportunity to stress the fact that infection played a key role in magnifying the protein energy malnutrition in children.

This experience in training the CHWs through an active involvement in epidemiological exercises and in the analysis at the micro-level has laid bare the fact that there is much more to the MCH services than what meets the eye. This has also awakened the group to the fact that there is scope for long-term ground work to standardise and stabilize the training and sharing of experience.

CHWs AS PARTNERS IN HEALTH-CARE :

The training of CHWs has been very innovative. The content of training has covered the basis of health, and learning through situational analysis has been built over it. Three VHWs were initially trained and their status has been subsequently upgraded to help in the lab with diagnostic skills in the treatment of common illness and to train the new VHWs. The training is done by the doctors themselves and teaching aids such as slides and charts are used to answer the curiosity of the CHW regarding physiology and anatomy. the training methodology is evolving from time to time and it was considered a learning experience for the group itself. The CHWs are partners in health care and no hierarchical levels exist.

Therefore, no bottlenecks and hence there is free flow of information within the group. The CHWs are chosen by the group from the lower strata of the community. They were semi-literates and curiously all were men. The CHWs were paid by the group and the group themselves operating on a low key do not feel it practical to have CHWs supported by the community.

While involved with their work on a micro-level MGS-G has kept its interest alive with groups in and around not only in the field of health per se but other issues outside of Mongrol such as the problems of oustees of the Narmada project and the landless tribals of Lachharas. The objective of MGS-G was to explore well into the problem of mother and child through identifying the causal factors both at the micro and macro-level and orient the CHWs suitably to these problems. MGS-G's awareness to the comlex objectives is different from others and to put it in their own words, "theirs is fragmented, simplistic, mechanistic and unnecessarily sentimental, devoid of hard content and in great danger of being degenerated into empty rituals".

In recognition of the fact that MGS-G is a group of intellectuals who are evolving the dialectics of community health, the recommendations made to Oxfam based on the study of ten different projects in the south, were taken up for discussions with them. Regarding the recommendation that community health activity should be a part of total development, the group felt that it is more acceptable to say that the projects should not only be health oriented but be aware of other problems that effect the lives of people and be prepared to play an active role in bridging the gap.

Secondly, each project that come for funding should at least address a genuine problem of community health. In addition, Oxfam should re-formulate the evaluation criteria and assess the process development to initiate the community health movement. Oxfam should also locate expertise to help the projects understand their problems in proper perspective and assess the capacity of the projects to handle them over the years.

Finally, Oxfam should fund a range of projects that have varied understanding of community health and capability to handle the problems, so much so, it contributes to the evolution of the science of community health.

Table 1 : Profile of the Projects where the VHWs have been Trained

Sl. No.	Name of the project	Main Thrust of the CH Programme	Total population covered	No. of CHW in the programme	Supportive programmes	Oxfam Funding continues
1.	HNS-K	Curative oriented : emphasis on health education	10 Villages	16	Mahila Mandals Maternity homes	NO
2.	HNM-A	Originally on Nutrition rehabilitation. curative clinics and health education	35 villages	38	NIL	NO
3.	HKS-T	Maternal child health programmes, the participation of the people in contributing to the programme inputs is through the CRS food.	110 villages	275 v. guides	Mathar Sangrams, creation of the village development fund.	YES
4.	THS-T	Leprosy treatment, and follow-up for a total population of 3 Lakhs. Aims at integrating the esisting programmes of the hospital under one umbrella as the community development program.	Population covered by the CH Dept. is spread over 7 villages	16	S. Welfare, Village upliftment, nonformal education, sponsorship rehabilitation, training, consultancy and communication	NO
5.	TWS-T	Provide medical help to the remote areas of the tribal areas, together with preventive services through the VHWs and other welfare programmes.	9 scattered areas of tribal settlements.	13	Rehabilitation, farms, sponsorship schemes	YES
6.	INS-K	Total development aimed at.	12 villages	18	Rural industries, Artisan projects, Dairy co-operative for women.	NO
7.	DGS-T	Health care delivery with emphasis on infant nutrition+Referral service	60,000 1 block	--	Income generating programs	NO
8.	DNS-A	Leprosy care, Extension of Health care to the neighbouring villages.	20 villages	30	NIL	NO
9.	RJS-A	Community Health with a centrally-based curative care center	15 villages	15	Mobile Clinics, Training for income generation programs	NO
10.	MGS-G	Community Health Programme with a research orientation	5 villages	5	Non-formal education	YES

Table II : Participatory components of the projects

	HKS-T	TWS-T	HNS-K	THS-T	TNS-K	DGS-T	HNM-A	DNS-A	RJS-A
Key									
A. Highly Participative									
B. Participative									
C. Somewhat Participative									
D. Non-participative									
E. Authoritarian									
I Project planning process:									
A. Through initial open discussions with the community	A	A	B	B	B	C	D	B	B
B. Through a discussion of the project proposal with the opinion leaders									
C. Through discussions with government/ non-government organizations at district/block level									
D. A project thrust from outside without discussions									
E. A project imposed in absolute disregard of community's wishes									
II Identification of Needs :									
A. By the people themselves	A	B	E	B	D	C	D	D	D
B. By local opinion leaders									
C. By a government agency									
D. By a centrally sponsored scheme									
E. By fiat									

Contd...

	HKS-T	TWS-T	HNS-K	THS-T	TNS-K	DGS-T	HNM-A	DNS-A	RJS-A
III Extent of resource mobilization for the Project :									
A. By the community	B	C	D	D	C	D	D	D	D
B. By the community and others									
C. Through matching contributions									
D. Through massive external assistance									
E. No contribution from the community									
IV Identification of Community Health Workers :									
A. By the community with its own criteria	A	C	C	C	C	C	C	C	C
B. By the community with imposed criteria									
C. Appointment of local persons by outside implementing agency									
D. Appointment of outsiders									
V Development of social skills/technical skills :									
A. Through short, local pre-service training followed by regular, on the job in-service training, in parallel with the training of the trainers from within the community	A	B	B	B	B	C	B	B	B
B. Through short, local pre-service training but not followed by regular on-the-job in-service training.									
C. Through pre-service training within the district/town									
D. No training									

Contd...

	HKS-T	TWS-T	HNS-K	THS-T	TNS-K	DGS-T	HNM-A	DNS-A	RJS-A
VI Project Implementation :									
A. Under community control (esp. remuneration of P. workers)	A	C	D	C	C	C	C	C	C
B. Under community supervision									
c. With some community involvement									
D. With no community involvement									
VII Periodic evaluation/monitoring of projects :									
A. By the community	D	E	E	D	D	D	D	E	D
B. Some evaluation by the Community									
C. Outsiders evaluation with results reported to the target group.									
D. Outsiders evaluation not reported to target community									
E. No evaluation									

Adapted from : Report of the community participation workshop Agra, May 1981. organised by UNICEF, New Delhi PP 13-16.